Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CASTLE HILLS SURGERY CENTERS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-15-1848-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are seeking assistance in reference to a refund request issued by Texas Mutual Ins. Company... We submitted a rebuttal letter dated July 28, 2014 describing the connection between the current surgery and the initial date of injury. On September 03, 2014 we received a notice of determination from Texas Mutual indicating that our appeal had been denied and that a refund was still being requested. "

Amount in Dispute: $5,186.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has not been given the opportunity to take final action on the requestor's bill."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2014	29822, 29826 and 64418	$5,186.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative code §133.260 sets out the refund guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 424 – Overpayment recoupment. Requesting recoupment as service rendered is not related to the compensable injury. Requesting recoupment in the amount of $2,646.10.
   - 195 – Refund issued to an erroneous priority Payer for this claim/service. Promptly remit the refund and a copy of this notification to the address above, attn: Medical Refunds.

Issues

1. Did the insurance carrier request a refund within the time allowed per 28 Texas Administrative Code 133.260(b)?
2. Did the requestor appeal the refund request?
3. Did the insurance carrier act on the health care provider's appeal within 45 days after the date on which the health care provider filed the appeal?
4. Did the requestor remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal prior to the filing of MDR?

Findings

1. Per 28 Texas Administrative Code 133.260 "(a) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided."

   The requestor seeks resolution of an insurance carrier refund request for services rendered on May 15, 2014. On July 21, 2014, the carrier requested a refund from the requestor for CPT codes 29822, 29826 and 64416 for which it had reimbursed a total of $2,646.10. The division finds that the insurance carrier met the requirements of 28 Texas Administrative Code 133.260(a).

2. Per 28 Texas Administrative Code 133.260 (b) The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division. (c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment."

   The requestor responded to the refund request in its July 25, 2014, letter, stating "It is also our understanding that the dispute is for other multiple body parts, but there is no dispute of rotator cuff tendon rupture on the surgery authorization dated 05/05/14, for which this patient is being treated." The division finds that the requestor met the requirements of 28 Texas Administrative Code 133.260(b)(2).

3. Per 28 Texas Administrative Code 133.260 "(d) The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal."

   The insurance carrier acted on the health care provider's appeal on September 3, 2014. The division finds that the insurance carrier did not meet the 45-day timeframe requirement of §133.260 (d).

4. Per 28 Texas Administrative Code 133.260 "(e) If the insurance carrier denies the appeal, the health provider: (1) shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and (2) may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General)."

   In this case, the requestor received substantive notice of the alleged overpayment on July 21, 2014. The requestor submitted insufficient documentation to support that the refund was remitted to the insurance carrier after the denial of the appeal by the insurance carrier and before the submission of the medical fee dispute. The division finds that the refund dispute request for medical fee dispute resolution was submitted prematurely by Castle Hills Surgery Centers, due to the requestor not meeting the requirements of §133.260(e)(1).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the review of the refund request. The requestor has failed to establish that the dispute is eligible for review.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 10, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this Medical Fee Dispute (MFD) has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a MFD Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **20** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.